

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

317

Primary Registration District No.

500

Registrar's No.

38038805

STATE FILE NUMBER

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

FILED 05 64

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Ladue		c. CITY OR TOWN Ladue	
Length of stay in 1b 16 yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 34 Clermont Lane		d. STREET ADDRESS (If outside, give location) 34 Clermont Lane	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES BOYD WARE		4. DATE OF DEATH Month Day Year September 29, 1964	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1905
9. AGE (last birthday) 58		10. IF UNDER 1 YEAR Months Days Hours Min. 9 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pres. Treas.		10b. KIND OF BUSINESS OR INDUSTRY Cox Ware Corporation	
11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Russell Bissell Ware		13b. MOTHER'S MAIDEN NAME Eliza Boyd	
14. NAME OF HUSBAND OR WIFE Emma Coulter Ware		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II	
16. INFORMANT Emma Coulter Ware, 34 Clermont Lane		17. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the pancreas		INTERVAL BETWEEN ONSET AND DEATH 9 mos.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Feb. 15, 1964 to Sept. 29, 1964 and last saw him live on Sept. 28, 1964 Death occurred at 2:30 a m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Benjamin H. Charles M.D.		22b. ADDRESS 5505 Delmar Avenue Rd.	
22c. DATE SIGNED 9/29/64			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Oct. 1, 1964	23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR Ambruster Mortuary, 6633 Clayton Rd.		25. DATE RECD. BY LOCAL REG. 9-30-64	
26. REGISTRAR'S SIGNATURE John B. Murphy M.D.			

Dr. B. H. Chandler
Mo Pac Hosp.
1230 2100pm. 0-7-78

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Licensed Embalmer No. 4788
P. O. Address St Louis, Mo.

Note: The above ~~MUST BE~~ SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.